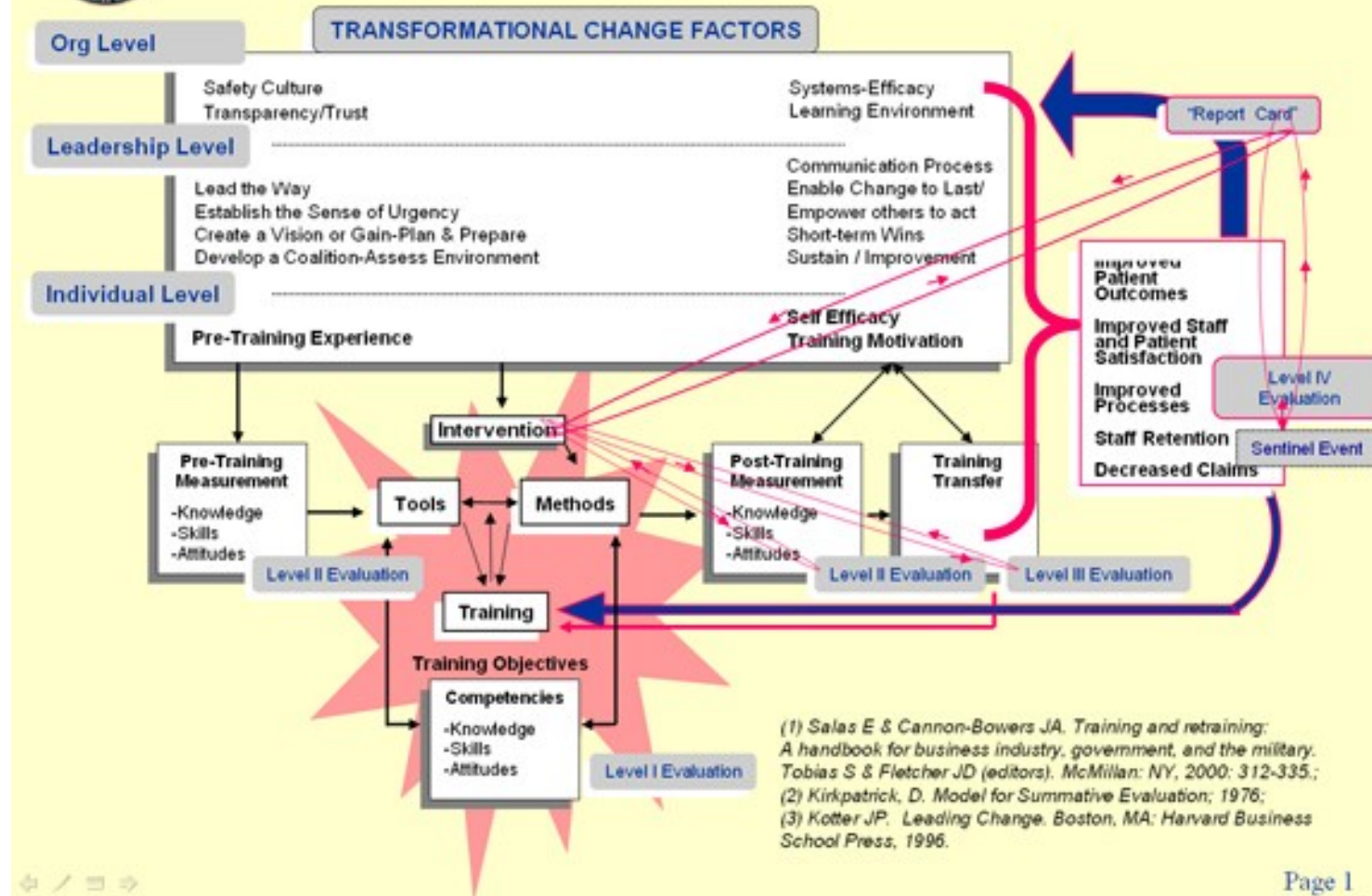




# Model for Change



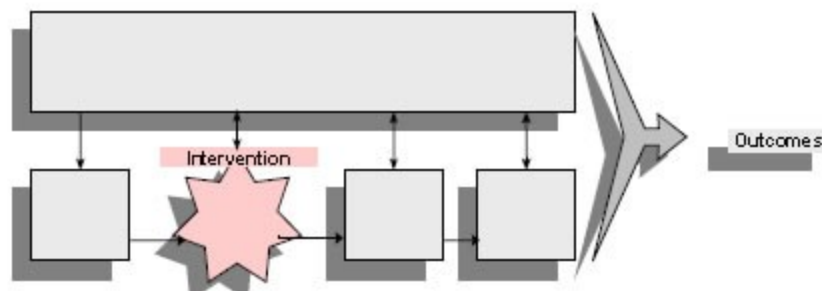
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## Designing for Safety: Military Health System's Approach to Change

*Rooted in decades of aviation research, the transition of formal teamwork into health care began with thoughtfully designed curriculum and team training and implementation work. Lessons learned combined with caregiver feedback indicated, however, that new strategies and methodologies were necessary to provide the customized organizational actions and resources necessary to effectively implement and sustain team-driven evaluation-based change.*



**Leveraging over two decades of research and practical application of teamwork in military settings and more than 5 years of medical team training, DoD couples experience expertise with a commitment to evaluation and on-going teamwork exploration.**



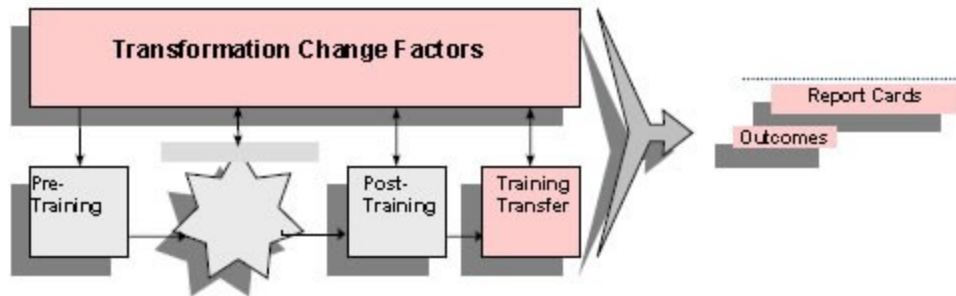
## *Experience and Expertise*

### **Intervention Design\***

**Training and Implementation:** Department of Defense scientific and practical work of subject matter experts, leaders, and staff provided the underpinnings of second generation team training and implementation development and redesign strategies:

- Standardized Team Knowledge, Skills, and Attitudes (KSAs)
- Practice-Specific Training Requirements
- Existing Teamwork Training Knowledge Leveraged
- Standardized Training Specifications

DoD has the largest health care team trained force in the world, and experience indicates that training and training evaluation are difficult to sustain without the support and structure provided by organizational actions of culture change. With the duty to design for safety, “preventing error means designing the health care system at all levels to make it safer” (IOM, 1999), so more work was needed.



## *Evaluation and Exploration*

### **Transformation Change Factors\***

Leveraging lessons learned, we designed a transformational change factors construct model. This heuristic systems approach to creating a culture of safety is a blueprint that remains dynamic over time. The construct, composed of the theory of Salas (training), Kirkpatrick (evaluation), and Kotter (culture change), provides a shared mental model for members at all levels of an organization. Individuals can visualize the impact of their role on the structure and process of patient safety initiatives, see how roles overlap, and understand how to work together in the larger sense of patient care teams to provide the integrated approach necessary for achieving a safety net for health care systems.

*Prepared by Heidi King, US DoD Patient Safety Healthcare Team Coordination Program, Nov 2004, rev. Mar 2006.*

\* *AHRQ recommendations based on 2003 case study analysis performed by American Institutes for Research.*